that date. However, under the transitional rules of this paragraph (i)(4), the plan must give *D* an opportunity to enroll that continues for at least 30 days, with coverage effective no later than July 1, 2001. (Additionally, October 1, 1999 is *D*'s enrollment date under the plan and the period between October 1, 1999 and July 1, 2001 is treated as a waiting period. Furthermore, if the plan sponsor has not elected to exempt the plan from limitations on preexisting condition exclusion periods, any preexisting condition exclusion period must be administered in accordance with §146.111. Accordingly, any preexisting condition exclusion period permitted under §146.111 will have expired before July 1, 2001.)

Example 2. (i) *Facts.* Individual *E* was hired by a non-Federal governmental employer in February 1995. The employer maintains a self-funded group health plan with a plan year beginning on September 1. Under the terms of the plan, employees and their dependents are allowed to enroll when the employee is first hired without regard to any health factor. If an individual declines to enroll when first eligible, the individual may enroll effective September 1 of any plan year if the individual can pass a physical examination. All enrollees are subject to a 12-month preexisting condition exclusion period. The plan sponsor elected under §146.180 of this part to exempt the plan from the requirements of this section and §146.111 (limitations on preexisting condition exclusion periods) for the plan year beginning September 1, 1997, and renews the exemption election for the plan years beginning September 1, 1998, September 1, 1999, and September 1, 2000. *E* chose not to enroll for coverage when first hired. In June of 2001, *E* is diagnosed as having multiple sclerosis (MS). With the plan year beginning September 1, 2001, the plan sponsor chooses to bring the plan into compliance with this section, but renews its exemption election with regard to limitations on preexisting condition exclusion periods. The plan affords *E* an opportunity to enroll, without a physical examination, effective September 1, 2001. *E* is subject to a 12-month preexisting condition exclusion period with respect to any treatment *E* receives that is related to *E*'s MS, without regard to any prior creditable coverage *E* may have. Beginning September 1, 2002, the plan will cover treatment of *E*'s MS.

(ii) *Conclusion.* In this *Example 2,* the plan complies with the requirements of this section. (The plan is not required to comply with the requirements of §146.111 because the plan continues to be exempted from those requirements in accordance with the plan sponsor's election under §146.180.)

[66 FR 1412, Jan. 8, 2001, as amended at 66 FR 14078, Mar. 9, 2001]

§146.125 Applicability dates.

(a) *General applicability dates*—(1) *Non-collectively bargained plans.* Part A of title XXVII of the PHS Act and §§146.101 through 146.119, §146.143, §146.145, 45 CFR part 150, and this section apply with respect to group health plans, and health insurance coverage offered in connection with group health plans, for plan years beginning after June 30, 1997, except as otherwise provided in this section.

(2) *Collectively-bargained plans.* Except as otherwise provided in this section (other than paragraph (a)(1) of this section), in the case of a group health plan maintained pursuant to one or more collective bargaining agreements between employee representatives and one or more employers ratified before August 21, 1996, Part A of Title XXVII of the PHS Act and §§146.101 through 146.119, §146.143, §146.145, 45 CFR part 150, and this section do not apply to plan years beginning before the later of July 1, 1997, or the date on which the last of the collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after August 21, 1996). For these purposes, any plan amendment made under a collective bargaining agreement relating to the plan, that amends the plan solely to conform to any requirement of such part, is not treated as a termination of the collective bargaining agreement.

(3) *Preexisting condition exclusion periods for current employees.* (i) *General rule.* Any preexisting condition exclusion period permitted under §146.111 is measured from the individual's enrollment date in the plan. This exclusion period, as limited under §146.111, may be completed before the effective date of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for his or her plan. Therefore, on the date the individual's plan becomes subject to part A of title XXVII of the PHS Act, no preexisting condition exclusion may be imposed with respect to an individual beyond the limitation in §146.111. For an individual who has not completed the permitted exclusion period under HIPAA, upon the effective date for his or her plan, the individual may use creditable coverage that the person had as of the enrollment date to

reduce the remaining preexisting condition exclusion period applicable to the individual.

(ii) *Examples.* The following examples illustrate the requirements of this paragraph (a)(3):

Example 1: (i) Individual *A* has been working for Employer *X* and has been covered under Employer *X*'s plan since March 1, 1997. Under Employer *X*'s plan, as in effect before January 1, 1998, there is no coverage for any preexisting condition. Employer *X*'s plan year begins on January 1, 1998. *A*'s enrollment date in the plan is March 1, 1997, and *A* has no creditable coverage before this date.

(ii) In this *Example,* Employer *X* may continue to impose the preexisting condition exclusion under the plan through February 28, 1998 (the end of the 12-month period using anniversary dates).

Example 2: (i) Same facts as in *Example 1*, except that *A*'s enrollment date was August 1, 1996, instead of March 1, 1997.

(ii) In this *Example*, on January 1, 1998, Employer *X*'s plan may no longer exclude treatment for any preexisting condition that *A* may have; however, because Employer *X*'s plan is not subject to HIPAA until January 1, 1998, *A* is not entitled to claim reimbursement for expenses under the plan for treatments for any preexisting condition received before January 1, 1998.

(b) *Effective date for certification requirement*—(1) *General.* Subject to the transitional rule in §146.115(a)(5)(iii), the certification rules of §146.115 apply to events occurring on or after July 1, 1996.

(2) *Period covered by certificate.* A certificate is not required to reflect coverage before July 1, 1996.

(3) *No certificate before June 1, 1997.* Notwithstanding any other provision of this part, in no case is a certificate required to be provided before June 1, 1997.

(c) *Limitation on actions.* No enforcement action is to be taken, under, against a group health plan or health insurance issuer with respect to a violation of a requirement imposed by part A of title XXVII of the PHS Act before January 1, 1998, if the plan or issuer has sought to comply in good faith with such requirements. Compliance with this part is deemed to be good faith compliance with the requirements of part A of title XXVII of the PHS Act.

(d) *Transition rules for counting creditable coverage.* An individual who seeks to establish creditable coverage for periods before July 1, 1996 is entitled to establish such coverage through the presentation of documents or other means in accordance with the provisions of §146.115(c). For coverage relating to an event occurring before July 1, 1996, a group health plan and a health insurance issuer are not subject to any penalty or enforcement action with respect to the plan's or issuer's counting (or not counting) such coverage if the plan or issuer has sought to comply in good faith with the applicable requirements under §146.115(c).

(e) *Transition rules for certification of creditable coverage*—(1) *Certificates only upon request.* For events occurring on or after July 1, 1996 but before October 1, 1996, a certificate is required to be provided only upon a written request by or on behalf of the individual to whom the certificate applies.

(2) *Certificates before June 1, 1997.* For events occurring on or after October 1, 1996 and before June 1, 1997, a certificate must be furnished no later than June 1, 1997, or any later date permitted under §146.115(a)(2) (ii) and (iii).

(3) *Optional notice*—(i) *General.* This paragraph (e)(3) applies with respect to events described in §146.115(a)(2)(ii), that occur on or after October 1, 1996 but before June 1, 1997. A group health plan or health insurance issuer offering group health coverage is deemed to satisfy §§146.115 (a)(2) and (a)(3) if a notice is provided in accordance with the provisions of paragraphs (e)(3)(i) through (e)(3)(iv) of this section.

(ii) *Time of notice.* The notice must be provided no later than June 1, 1997.

(iii) *Form and content of notice.* A notice provided under this paragraph (e)(3) must be in writing and must include information substantially similar to the information included in a model notice authorized by CMS. Copies of the model notice are available at the following website—www.cms.gov (or call (410) 786–1565).

(iv) *Providing certificate after request.* If an individual requests a certificate following receipt of the notice, the certificate must be provided at the time of the request as set forth in §146.115(a)(2)(iii).

(v) *Other certification rules apply.* The rules set forth in §146.115(a)(4)(i) (method of delivery) and (a)(1) (entities required to provide a certificate) apply with respect to the provision of the notice.

[62 FR 16958, Apr. 8, 1997; 62 FR 31694, June 10, 1997, as amended at 66 FR 1420, Jan. 8, 2001; 66 FR 14078, Mar. 9, 2001]

Subpart C—Requirements Related to Benefits

§146.130 Standards relating to benefits for mothers and newborns.

(a) *Hospital length of stay*—(1) *General rule.* Except as provided in paragraph (a)(5) of this section, a group health plan, or a health insurance issuer offering group health insurance coverage, that provides benefits for a hospital length of stay in connection with childbirth for a mother or her newborn may not restrict benefits for the stay to less than—

(i) 48 hours following a vaginal delivery; or

(ii) 96 hours following a delivery by cesarean section.

(2) *When stay begins*—(i) *Delivery in a hospital.* If delivery occurs in a hospital, the hospital length of stay for the mother or newborn child begins at the time of delivery (or in the case of multiple births, at the time of the last delivery).

(ii) *Delivery outside a hospital.* If delivery occurs outside a hospital, the hospital length of stay begins at the time the mother or newborn is admitted as a hospital inpatient in connection with childbirth. The determination of whether an admission is in connection with childbirth is a medical decision to be made by the attending provider.

(3) *Examples.* The rules of paragraphs (a)(1) and (a)(2) of this section are illustrated by the following examples. In each example, the group health plan provides benefits for hospital lengths of stay in connection with childbirth and is subject to the requirements of this section, as follows:

Example 1. (i) A pregnant woman covered under a group health plan goes into labor and is admitted to the hospital at 10 p.m. on June 11. She gives birth by vaginal delivery at 6 a.m. on June 12.

(ii) In this *Example 1*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 6 a.m. on June 14.

Example 2. (i) A woman covered under a group health plan gives birth at home by vaginal delivery. After the delivery, the woman begins bleeding excessively in connection with the childbirth and is admitted to the hospital for treatment of the excessive bleeding at 7 p.m. on October 1.

(ii) In this *Example 2*, the 48-hour period described in paragraph (a)(1)(i) of this section ends at 7 p.m. on October 3.

Example 3. (i) A woman covered under a group health plan gives birth by vaginal delivery at home. The child later develops pneumonia and is admitted to the hospital. The attending provider determines that the admission is not in connection with childbirth.

(ii) In this *Example 3*, the hospital length-of-stay requirements of this section do not apply to the child's admission to the hospital because the admission is not in connection with childbirth.

(4) *Authorization not required*—(i) *In general.* A plan or issuer may not require that a physician or other health care provider obtain authorization from the plan or issuer for prescribing the hospital length of stay required under paragraph (a)(1) of this section. (*See also* paragraphs (b)(2) and (c)(3) of this section for rules and examples regarding other authorization and certain notice requirements.)

(ii) *Example.* The rule of this paragraph (a)(4) is illustrated by the following example:

Example. (i) In the case of a delivery by cesarean section, a group health plan subject to the requirements of this section automatically provides benefits for any hospital length of stay of up to 72 hours. For any longer stay, the plan requires an attending provider to complete a certificate of medical necessity. The plan then makes a determination, based on the certificate of medical necessity, whether a longer stay is medically necessary.

(ii) In this *Example*, the requirement that an attending provider complete a certificate of medical necessity to obtain authorization for the period between 72 hours and 96 hours following a delivery by cesarean section is prohibited by this paragraph (a)(4).

(5) *Exceptions*—(i) *Discharge of mother.* If a decision to discharge a mother earlier than the period specified in paragraph (a)(1) of this section is made by an attending provider, in consultation with the mother, the requirements of paragraph (a)(1) of this section do not